RITE SHARE DESIGN AND IMPLEMENTATION:

LESSONS LEARNED IN PHASE I

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EXECUTIVE SUMMARY

Historically, Rhode Island has been aggressive in addressing the problem of uninsured residents, implementing programs that both expand eligibility and encourage increases in enrollment. The state's Medicaid managed care program, RIte Care, covered over 108,000 people at the end of 2000 up from around 73,000 in 1999. The program encompasses some of the broadest eligibility expansions and benefit packages in the country.

In the spring of 2001, Rhode Island implemented RIte Share, a Premium Assistance Program, as part of the state's strategy to maximize health insurance coverage. The RIte Share program is oriented toward encouraging people who are eligible for state medical assistance to remain in their employer-sponsored plan by providing financial subsidies for employee premium costs. The intent of the program design is to coordinate with the existing commercial insurance market, to cause a minimum of disruptions for insurers, employers, and providers while ensuring continuity of coverage for enrollees. Further, the goal is to maximize the state's opportunity to benefit from the cost-effectiveness of insuring people through their employers and leveraging costs through employer contributions. In implementing RIte Share, Rhode Island became one of only a handful of states that are experimenting with opportunities to expand health insurance coverage using premium assistance programs to integrate public and commercial health insurance sectors and taking advantage of Medicaid and SCHIP matching funds.

In designing the program, Rhode Island initially developed several features that are geared toward minimizing market disruption and improving enrollment opportunities.

- *Payment to Employers instead of Employees*
- *Broad Standards for Qualifying Health Plans with Wrap-Around Benefits*
- *Employer-Based Cost-Effectiveness Testing*
- *Mandatory Enrollment under Both Medicaid and SCHIP*

The Rhode Island Department of Human Services commissioned this study to evaluate the initial rollout period of the program. The study examines each of the design features of the program as they impact employers, insurers, enrollees, and the state. Further, issues that the various stakeholders perceive as potential barriers to success of the program are identified. Information was gathered through key informant interviews with a non-randomly selected group of respondents from among employers, enrollees, insurers, brokers, advocates, providers and state administrators. The interviews were conducted in the late summer and fall of 2001. During that period some of the design features were being modified both according to the original phase-in plan and in response to implementation experiences. Some of the respondents' comments have, therefore, been addressed serendipitously.

This study is a point in time snapshot of a very young program. As the program grows it will be important to revisit this study to assess if the early observations of the respondents match their more extensive experiences.

STUDY RESULTS

Overall Comments

- *Employers generally are supportive of participating in the program and providing health insurance coverage but have concerns about whether the state will continue to support the program and/or will keep making changes they view as not in their interest.*

- *The RIte Care program is viewed as providing high quality care and positive health outcomes. There is concern that people will experience less continuity of care and access under RIte Share.*

- *Continued instability and lack of regulation in the small group commercial insurance market will lead to failure of the program as employers are priced out of health insurance or cost-shift more to employees.*

- *Rite Share presents the opportunity to broaden the revenue streams supporting the state's health care expenses and to leverage state dollars with employer contributions.*

Employer Payments and Direct Member Payments

- *Mandatory enrollment coupled with direct member payment gives the state greatest control over enrollment choices and maximizes program growth, but creates problems for employers and employees.*

- *The loss of control over whether to participate due to implementing direct member payments is not emphasized by employers and generally will not encourage them to drop insurance or try to get out of qualifying.*

Plan Qualifying and Wrap-Around Benefits

- *There is near universal agreement that the wrap-around benefits and co-payment coverage create administrative complexities and confusion.*

- *The bifurcated approach to coverage fragments the health care delivery system and the need for two insurance cards is confusing for providers and enrollees.*

- *Not creating a special RIte Share insurance plan was the right choice; subsidizing existing employer sponsored plans would be administratively easier.*

- *Access to comprehensive care and reducing the chance that out of pocket costs will deter seeking care are important – but the structure of the program may not assure access.*

Employer-Based Cost-Effectiveness Test

- *Universally seen as the most efficient approach – the only concern being that all eligible people get identified.*

Mandatory Enrollment

- *The best way for the state to maximize enrollment and control triage into the state's programs.*

- *Employers need to be able to project the number of people in their health plans and know when people will be coming into the benefit program. Rolling eligibility and recertification make it hard for them to plan their benefit packages and project costs.*

- *There is concern that lack of efficiency and effectiveness in adopting the added procedures by welfare field offices will leave people stranded without coverage while they try to gather required information.*

RECOMMENDATIONS

Based on the information gathered in this study, the following are recommended for improving the RIte Share program in the next phase:

- ***Increase information and education***
- ***Implement a data tracking system***
- ***Develop a mechanism for ongoing feedback from participants and stakeholders.***
- ***Establish a dedicated process for addressing the problems that rolling eligibility screening and recertification engender for employers***
- ***Re-evaluate the wrap-around approach.***
- ***Assess the impact of the program on continuity of care and the delivery system***
- ***Encourage state policy makers and legislators to increase oversight and reform of the small group market.***

The premium assistance approach has very little track record in other states. By taking this avenue, Rhode Island is serving as a testing ground for the rest of the nation. The lessons learned here can assist Rhode Island and other states in modeling the most attractive and successful programs.

**RITE SHARE DESIGN AND IMPLEMENTATION:
LESSONS LEARNED IN PHASE I**

INTRODUCTION

In the spring of 2001, Rhode Island implemented RIte Share, a Premium Assistance Program, as part of the state's strategy to maximize health insurance coverage. The RIte Share program is oriented toward encouraging people who are eligible for state medical assistance to remain in their employer-sponsored plan by providing financial subsidies for employee premium costs. The intent of the program design is to coordinate with the existing commercial insurance market, to cause a minimum of disruptions for insurers, employers, and providers while ensuring continuity of coverage for enrollees. Further, the goal is to maximize the state's opportunity to benefit from the cost-effectiveness of insuring people through their employers and leveraging costs through employer contributions. In implementing RIte Share, Rhode Island became one of only a handful of states that are experimenting with opportunities to expand health insurance coverage using premium assistance programs to integrate public and commercial health insurance sectors and taking advantage of Medicaid and SCHIP matching funds.

This study was undertaken to evaluate the initial rollout period of the program. Specifically, the study examines each of the design features of the program as they impact employers, insurers, enrollees, and the state. Further, issues that the various stakeholders perceive as potential barriers to success of the program are identified.

Background

Historically, Rhode Island has been aggressive in addressing the problem of uninsured residents, implementing programs that both expand eligibility and encourage increases in enrollment. The state's Medicaid managed care program, RIte Care, covered over 108,000 people at the end of 2000 up from around 73,000 in 1999. The program encompasses some of the broadest eligibility expansions and benefit packages in the country.

Advocates and analysts alike have touted RIte Care for increasing access and improving health outcomes significantly. As a result, Rhode Island is the nation's leader in lowest percent of the general population without health insurance at 6.2% (US Census, 2000) and an astoundingly low 2.4% among children. Advocates for the underserved praised RIte Care during the interviews as "a really elegant system…able to deliver services fairly seamlessly"[2]. Neighborhood Health Plan of Rhode Island (NHPRI), the non-profit community health center affiliated Medicaid plan that covers over half of all RIte Care beneficiaries, leads plans around the country in primary and preventive health care outcome statistics.

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[2] Respondents participating in the study were assured confidentiality and therefore are not identified.

The RIte Share program was implemented in the spring of 2001 in response to several phenomena that occurred simultaneously in Rhode Island. First, RIte Care enrollment expanded significantly from 1998 to the end of 2000. Much of the increase was due to eligibility expansions and reduced enrollment barriers. Eligibility was increased to include preschool children and pregnant women up to 250% FPL, parents of MA children up to 185% FPL, children up to age 19 with family incomes up to 250%, in-center childcare providers, foster children, and alien children up to 250% FPL. At the same time, the state implemented an aggressive outreach program and streamlined the enrollment process. In 1998, the application form was cut to one page, required documentation reduced from 11 to 3 documents and mail-in applications were initiated in place of the face-to-face interview previously required. At the same time, an aggressive outreach program was implemented providing incentive-based 18-month contracts with 32 community agencies. The program included radio ads, school-based outreach, and direct outreach in small employer workplaces.

Activities in the broader health insurance market contributed significantly to the instability in the health care arena and the RIte Care program. In spite of a robust economy and several years of single-digit health insurance rate inflation, costs of insurance began to escalate – particularly for small businesses. At the same time, in the fall of 1999 Harvard Pilgrim Health Plan and Tufts Health Plan moved out of the Rhode Island market potentially stranding tens of thousands without health insurance. The combination of increased costs and reduced choices in the commercial market resulted in a crisis of access to health insurance for low-income workers and their employers. This, combined with the constricting of the market to two commercial carriers, had immediate and long lasting effects on the state's medical assistance program and the potential for increased rates of uninsurance.

Similar events in other states have led to a range of programmatic responses. Some states have focused on increasing the rate at which employers, particularly small employers, offer health insurance benefits. These efforts include direct payments to employers, tax incentives, and indirect subsidies to insurers through risk reduction mechanisms such as state reinsurance pools for small group products. A related approach is to increase the employee benefit participation rates in shops where benefits are already offered, such as premium assistance programs and Medicaid and/or SCHIP buy-in programs. Finally, mechanisms for structurally modifying or reforming the commercial insurance market have been undertaken. These approaches include small group reforms like mandating community rating, creating rate bands and other rate restrictions, guaranteed issue and renewal, portability requirements and pre-existing exclusion limitations, and modifying benefit standards. Purchasing pools have been developed in several states as well. While most of these are restricted to people with high medical risk and uninsurables, some states have broadened their pools targeting public programs, small employers, and public employees. The former tend to have limited enrollment with very high rates due to adverse selection. The latter approaches have the potential to exert significant purchasing power in the marketplace bringing significant savings to the state and other pool members. Another market modification approach is to develop a limited benefit product coupled with a restricted rate ceiling targeting small employers.[3]

In response to the instability in the commercial health insurance market and the concurrent explosion in RIte Care enrollment, the Governor and legislature initiated a process that resulted in Health Reform 2000, legislation directed at both containing the trend in RIte Care enrollment and rationalizing the instability in the commercial market. This legislation, a result of months of meetings among insurers, employers, brokers, state administrators, advocates, and legislators explicitly addressed both the public and private sides of the dilemma. In addressing the RIte Care program, the legislation calls for measures that are expected to deter people from leaving employer sponsored insurance (ESI) such as waiting periods and establishes vehicles for cost-sharing at the upper strata of eligibility, including co-payments and premium-sharing. RIte Share, the ESI premium-assistance program, was established and targeted people enrolled in RIte Care who have access to ESI. Stemming the growth of RIte Care through these mechanisms is critical to maintaining existing eligibility levels; failure of these initiatives may well lead to eligibility pullbacks.

On the market stabilization side, the legislation addresses aspects of the commercial market that are understood to impact most directly how the small group product line behaves. Although premium increases are being experienced in all sectors, the small group market is the most volatile in terms of both price and product availability. Health Reform 2000 instructed the Department of Business Regulation to compress rate bands and provided for guarantee issue of a basic health plan.

Since the spring of 2001, enrollment in RIte Care has, in fact, leveled. In part this is due to ending the aggressive outreach program; additionally there have not been any eligibility expansions. On the commercial side, however, the state has been slow in implementing the small group market reforms and premium rates have continued to spiral. Insurance premium costs are increasing at a pace not seen since the early 1990's and are expected to be well over 20% this year for small employers.

As is borne out in comments provided in this study, the two sides of the issue cannot be separated. Skyrocketing premium costs and restricted product access in the small group market can only result in more people being uninsured, primarily low-income workers. This will occur not only because fewer people will have access to affordable products, but also because the more the enrollee has to pay for premiums, the higher the required subsidy, the fewer people who will pass the cost-effectiveness test required by RIte Share. The result is either more people without health insurance or a re-

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[3] Beginning in 1997 when rates of uninsurance were higher and rising, Rhode Island explored several models for expanding coverage. The first of these was a cooperative health care services purchasing strategy. A benefit program would be designed and put out to bid to providers, insurers would be able to compete to market the product, public employee unions, employers, and others would be solicited. This approach was abandoned in 1999 and replaced with a model that developed a combined buy-in (< 10 employees) and commercially marketed (11-24 employees) limited benefit package marketed only to small employers and available only for employees eligible for medical assistance. This was revised into a premium assistance program in 2000.

escalation of enrollment in RIte Care…or both. In the context of a downturn in the economy and rising unemployment, the rate of ESI will most likely decline exacerbating the problem.

RITE SHARE DESIGN

RIte Share can be understood as a response to Rhode Island's success in expanding health insurance coverage to low income and underserved people. Given the economic and market pressures that were building during 1999-2000, the state needed to act to protect their successes. In implementing RIte Share, Rhode Island is taking on a problem that has not been effectively addressed yet anywhere in the nation. As noted above, several states have implemented a range of initiatives aimed at expanding health insurance, some of these focus on building on the employer-based system. These states have had at best limited success.

Rhode Island's initiative is an effort to integrate public and private sectors. Certainly the ultimate goal for the state is to maintain health insurance coverage for as many residents as possible and to protect its existing RIte Care program. However, in a complex system with multiple stakeholders with varied and contradictory interests, reaching this goal is not simple. During the design process the Business Advisory Committee and the Implementation Planning Group were consulted on each design feature and program strategy. Each of the decisions regarding the design of the program were guided by a set of considerations:

1. *How well does this design feature fit in with and minimize disruption of the commercial insurance market?*

2. *How well does this design feature minimize disruption and administrative burdens for enrollees, employers, insurers, and providers?*

3. *How well does this design feature leverage state investments in health insurance coverage for the underserved and uninsured?*

In spite of the attention paid to involving the vested communities in the process, in almost every instance each decision made creates alternate obstacles. For example, approaches to maximize program enrollment may very well limit how voluntary program participation is; minimizing disruption of the private sector may well lead to greater complexities and administrative burdens for the state and make the whole program overly cumbersome. In the end, RIte Share is crafted so as to try to meet the dual goals of maximizing private sector buy-in by including design features that minimize disruptions, and maintaining the state's track record of excellence in providing broad access to comprehensive services for its low income and medically underserved citizens. These laudable goals are difficult to attain and require entering some very untested waters.

The RIte Share Approach

The RIte share program pays an enrolled employee's share of the premium cost for qualified employer sponsored health insurance. By maximizing use of ESI, the state believes it can save money through leveraging employer contributions and providing health insurance through a less expensive vehicle than straight enrollment in RIte Care. The program also may benefit the commercial small group market and particularly small employers, as it could increase group participation and thereby potentially reduce plan costs and administrative overhead. If successful, the program could contribute to the dual goals of Health Reform 2000 while also continuing to expand health insurance coverage in the state.

In designing the program, Rhode Island initially developed several features that are geared toward minimizing market disruption and improving enrollment opportunities.

- *Payment to Employers – the initial approach for providing premium subsidy is to directly pay the employers for their enrolled employees' shares of health insurance premiums.*

- *Broad Standards for Qualifying Health Plans with Wrap-Around Subsidies – most commercial workplace-based group plans are qualified as RIte Share plans. Additional benefits and co-pay wrap-around are provided directly by the state through the medical assistance program.*

- *Employer-Based Cost-Effectiveness Test – using the employer group as a whole to evaluate whether it is more cost-effective for the state to enroll eligible people in RIte Share than RIte Care improves administrative simplicity while potentially reducing costs for the employer due to adverse selection based on family size.*

- *Mandatory Enrollment under Both Medicaid and SCHIP – if a RIte Care eligible employee has access to a qualified participating employer-sponsored health insurance program they must enroll in RIte Share as a condition of eligibility for medical assistance.*

These design features are meant to address potential barriers to the success of the program. The state's approach in putting together the program is to involve stakeholders in the design and implementation process and to adjust the design features in response to their concerns. The end result is a design that attempts to fit with the existing commercial system while also providing enabling benefits to ensure continued access to care for low-income enrollees formerly in RIte Care. Meeting the preferences of the insurers, employers, and providers while maintaining comprehensive benefits and broad eligibility for public assistance preferred by the state and advocates for medically underserved people is challenging. Added to the delicate balance are the political exigencies to limit RIte Care expenditures and enrollment, and to minimize political pressure to reduce eligibility and/or benefits.

Initially people entered the program because they were enrolled in RIte Care. RIte Share identified employers who had employees enrolled in RIte Care then contacted the employers to encourage them to participate in the program. If they expressed interest, the employer's group health plan was evaluated to see if it qualified under the RIte Share program. Qualification is based on plan features such as amount of co-pay, whether there is a deductible, etc. If qualified, a plan is then tested to determine whether it is more cost-effective for the state to keep an eligible individual or family in RIte Care paying the full cost of their coverage or to move them to RIte Share and subsidize the commercial premiums. The state is able to receive federal matching funds for RIte Share enrollees who qualify for medical assistance. During Phase I, enrollment in RIte Share was voluntary for RIte Care eligibles; the change to mandatory enrollment was instituted in November 2001. With the change to mandatory enrollment the state is able to identify potential RIte Share enrollees during the initial and recertification screening processes for medical assistance and direct individuals into the most cost-effective program for the state at that point.

Along with direct contact, RIte Share implemented a marketing strategy that included doing information sessions with insurers, brokers, employers, and advocates. Radio and television ads were added as the program rolled out.

Once enrolled in RIte Share, the employee has access to a broad package of benefits. The employee becomes a member of the employer's group plan and accesses providers and services included in that plan through the commercial carrier. In addition, the state provides wrap-around coverage for services included in the RIte Care program but not the commercial plan and for co-payments included in the employer's plan. The enrollee carries two cards, one for the commercial plan and a medical assistance card for the wrap-around coverage.

At the onset of the program the decision was made to pay employers for the employee's subsidy of the premium. Several months into program implementation the state added Direct Member Payments, i.e. sending the premium subsidy checks to the enrollees as opposed to the employers.

It is important to note that RIte Share is focused at this point only on employees in shops where benefits are presently offered. It is not a program designed to increase the number of employers offering health benefits. As noted above, initially enrollment strategy was based on identifying employers with employees enrolled in RIte Care and moving those employees into their employer sponsored plans. This approach focused on RIte Care enrollment reduction. With the addition of the mechanism through which enrollment in RIte Share occurs at the point of eligibility determination, focus moves also to limiting new enrollment in RIte Care and optimizing RIte Share enrollment. Stabilizing RIte Care is essential for protecting eligibility expansions and benefits, particularly during the economic downturn. As of December 1, 2001, there were 96 participating employers and 150 enrolled employees in the program.

STUDY DESIGN

This study is based on key informant interviews (41) with stakeholders identified through interviews with state administrators, review of program meeting minutes and documents, and recommendations from other key informants[4]. A copy of the interview protocol is located in the Appendix. The questions served primarily as guides to explore the key design features and general impressions and reactions of the respondents. Interviews were conducted over the phone and transcribed for analysis. Respondents were assured confidentiality to encourage candid answers. To maximize reliability the same researcher conducted all interviews.

The interviews were conducted in the late summer and fall of 2001. During that period some of the design features were being modified both according to the original phase-in plan (i.e. the move to mandatory enrollment) and in response to implementation experiences (i.e. direct member payment). Some of the respondents' comments have, therefore, been addressed serendipitously. Some of the changes already underway will alleviate barriers identified in the interviews, while others may exacerbate them.

Several caveats are important before the results are discussed below. First, this study is based on conversations with a small number of non-randomly selected representatives. As such, the responses in no way represent a consensus of any stakeholder group on any of the issues discussed. Nor do they represent a statistically significant set of findings. Respondents' personal opinions and experiences no doubt played a strong a role in their responses. In no case was there a "party line" or complete agreement among respondents from the same stakeholder group. For example, employers were as likely to support government health access programs and insurance market oversight, as they were to decry government intervention in favor of competition. Some insurance brokers wholeheartedly supported the RIte Share program and others thought it was inappropriate. The results discussed below, then, offer a glimpse into the variety of reactions and experiences to a new and complex program.

The timing of the study during the initial implementation phase may have biased respondents toward highlighting problems and issues. Any start-up has problems and quirks that need to be worked out. In the case of a program as complex as RIte Share, this is all the more true. It is expected that there will be confusion among stakeholders, that state systems will have glitches, and that unforeseen problems will arise. Everything is fluid; there are no established patterns. As a result, it is not unusual or unexpected that people focus on what is wrong – what does not work for them – and on the way things are different from what they are used to. Not uncommonly respondents in the study focused on broad negative issues while also responding positively to each of the specific design feature questions, or conversely praised the program and then went on to pick apart every design feature.

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[4] Respondents are as follows: State Administrators (6); Insurers (3); Employers (Non-participating 3; Participating 7; Not Eligible 3); Independent Brokers (5); Providers (6); Advocates (4); Employees (4).

Compounding the tendency of the stakeholders to highlight their discomforts, during the time of the study the state changed some of the program features and procedures. This evolution of the program is also to be expected during initial rollout as the effects of pre-implementation decisions are observed. Reactions to the design changes, particularly the payment mechanism and mandatory enrollment, were fresh and strong and are reflected in the comments of the respondents.

STUDY RESULTS

Setting the Framework

The primary focus of the study is to assess how well the four design features identified above contribute to program acceptance and enrollment, and to evaluate how Phase I implementation is working. Information gathered from the respondents is meant to assist the state in identifying obstacles to program success and modifying the design of the program to improve it.

This study is a point in time snapshot of a very young program. It is important for understanding study results to remember that at the time the interviews were conducted very few businesses and employees were participating. While some of the employers had one or two employees enrolled in the program, most did not - even if the employer was registered as participating. Similarly, the majority of the providers had not encountered many RIte Share enrollees in their practices.[5] As the program grows it will be important to revisit this study to assess if the early observations of the respondents match their more extensive experiences. Similarly, there was confusion expressed by almost all respondents about how the program works, who is eligible, etc. This is not at all unexpected given the newness and complexity of the program and the fact that some of the design features were being modified as the program was being implemented.

Before discussing the results from the interviews, it is important to raise an issue brought up by many respondents and one that remains at the heart of assessing the program's success. There is some confusion over the ultimate goal of implementing the RIte Share program. The question raised not infrequently was whether the goal of the program is to move people out of RIte Care or to keep more people from coming in. Each of these goals dictates different approaches to where incentives are placed, how people are recruited into the program, and how program success is measured. As the state has recently added mechanisms to identify people coming into medical assistance and enroll them directly in RIte Share, this confusion will likely be resolved.

For state administrators, the overriding goal is to maintain political support for RIte Care and a strong public sector role in providing access to health insurance and health care for low income and medically underserved people. There was clear agreement that eligibility cutbacks are not an acceptable approach to control RIte Care costs.

[5] When the interviews began in the late summer of 2001, there were less than 50 employers and under 100 enrollees in the program.

Alternately, emphasis was placed on developing mechanisms for stabilizing RIte Care costs and creating opportunities to broaden the revenue streams coming into public programs. RIte Share is one such avenue along with implementing premium sharing and co-payments based on income for both RIte Care and RIte Share program participants.

The study interview protocol began with broad questions about the respondent's perception of the most glaring issues in health care and health insurance environments and their suggestions for addressing those issues. These questions formed the context for understanding answers to the specific design and implementation questions. An individual's understanding of how the health system works and about the government's role in addressing problems in the system will inform the range of options they can consider. This perception will influence the respondent's specific comments about the RIte Share program. For example, if someone believes that runaway costs are the biggest problem in the health care system and that government has an important role to play in addressing that problem, they are more open to premium-assistance programs and other government directed efforts. If, on the other hand, a person believes that government has no role to play and that pure competition in the marketplace is best, they will be less likely to feel that any efforts by the state are helpful and will find fault in the design of almost any program.

There was universal consensus among the respondents that rising costs and the increasing unaffordibility of health insurance were the most critical problems in the health care system. Pharmaceutical costs and utilization were seen as the main reasons for spiraling costs. Looking specifically at Rhode Island, the majority of respondents listed the restricted insurance market (only two commercial carriers, one of which dominates the market) and lack of state regulation of the insurance market as the two biggest issues.

In responding to these problems respondents most often supported more government intervention in the areas of regulating the insurance market, particularly in the small group arena, and providing programs that fill the gaps in coverage and reduce barriers to obtaining health insurance. Regulation and oversight was most frequently mentioned in reference to the specific problem in Rhode Island of the limited availability of commercial insurance options. Respondents across all categories of stakeholders identified a lack of oversight and control by the Department of Business Regulation as exacerbating the problem of increasing insurance premiums costs and declining access to affordable insurance plans for small businesses.

Several respondents stated that they prefer a pure market competition model, and that left unfettered by government regulation more insurers would be drawn into the Rhode Island market. These respondents also stated the need for identifying who the uninsured are and providing access to health care or health insurance "of some limited kind."

The problem of escalating commercial insurance premiums as a significant impediment to the success of RIte Share was not lost on the majority of the respondents regardless of the stakeholder group they belong to. It iss clear that it is believed that as insurance premium costs rise, more small employers will be driven out of the market. The practice of paying employees additional income in lieu of offering health benefits was cited as an increasing phenomenon in the state. As the employee's premium costs rise due to general increases along with increased cost-shift by employers, fewer shops will qualify for participation in RIte Share according to the cost-effectiveness requirements. Due to the disproportionate impact of rate increases on small businesses and low wage workers, these combined effects will mean an increase in RIte Care enrollees and/or uninsured people regardless of how well the RIte Share program is designed. Given the change in the broader economy and the increase in unemployment it is doubtful that the hardest hit employers will continue to feel compelled to offer health insurance as an incentive in the competition for labor.

Among health care providers and advocates there was a strong sense that there is inadequate attention being paid to the health care delivery system as opposed to health care financing. They cited uneven development between primary care and tertiary care, the lack of flexibility in viewing options for the delivery system, and an emphasis on health insurance models instead of health care access models for covering the uninsured and low income people. Within this group, however, representatives of institutional medicine tended to support more competition and less regulation while physicians and other primary care providers supported more rational distribution of resources and better oversight of hospital and technological growth.

Analysis of RIte Share Design Features

In evaluating how well each of the RIte Share design features works for each of the stakeholder group's attention will be paid to:

1. *Administrative ease or burden*
2. *Encouraging participation/enrollment and program growth*
3. *Optimizing opportunities for overall program success*

Following discussion of the design features, general issues raised by the respondents and recommendations are presented.

RIte Share Design: Who should get paid?

The issue of who should get the premium subsidy check, the employer or the employee, is important from a number of perspectives. Each approach both contributes to the potential success of the program and detracts from participation depending on whether one is considering administrative burden, participation recruitment, or overall success.

Initially, the position of the Business Advisory Committee and the state was to make the program as transparent as possible for employers. The belief was that if payments were made directly to the employees (Direct Member Payment – DMP) they would just blend in with the rest of the employees in the health plan and it would be business as usual. Under this approach, the RIte Care enrollee with access to an employer sponsored insurance plan makes the decision to enroll in the employer's group policy, or if the program is mandatory for RIte Care enrollees is placed in it, if the plan is qualified by the state and it costs less for the state to insure the person through their employer with a subsidy. In theory, the employer would not even be aware of the program.

During the early implementation period a decision was made by the state to begin the program with payments to employers instead. While initially there was a negative response, respondents from the employer group stated that they quickly understood that by making the payment directly to them the state had created a voluntary program and that they were put in the position of deciding whether or not to participate. This became the more acceptable position from their perspective. Recently, the state has decided to implement Direct Member Payment as well as employer payment. The reaction to this is discussed below.

The issue of who gets paid highlights the tension between trying to make the program as administratively transparent as possible for employers by giving the payments to members versus getting business buy-in by putting control over the choice to participate in the hands of employers by paying them. This conflict played out clearly in the interviews where it became apparent that the concern about transparency was not primary in the minds of stakeholders. Far greater concern was the tension between the reverse incentives to participate set up by the employer payment and the potential financial hardship and administrative difficulties created by the DMP.

Most stakeholders, regardless of their affiliation, supported employers receiving the subsidy payment. They cited the following reasons:

- *The particular niche for this program is low wage workers. If the employee is paid the subsidy then the employer will do a payroll deduction as with any other employee. The problem is there may not be anything left in the employee's check – actually there may not be enough to do the deduction.*

- *This is a highly transitional workforce, people come on and off the health plan all the time – if the employees get the check the employer will be out on a limb for their share while all the paperwork is being sorted out.*

- *It gives the employer the control over whether to participate and when to join.*

- *Employers would rather have the administrative add-on of processing the premium subsidy check than to have to chase after employees for their share.*

- *Administratively it is cleanest for everyone-particularly the state.*

- *Philosophically there is a strong aversion among employers, insurers, and providers to mandates and by moving the payment to employees the state in effect makes employer participation mandatory.*

- *Enrolled members live very close to the margin and if they do not receive their checks in time or have to chase after reimbursements they will not have money to live on or will use the premium subsidy for other purposes and create even greater hardship.*

- *Employees prefer to be treated the same as their coworkers, however, they cite concerns about confusion if they have to apply for reimbursement for the state or how the process would work if they get paid directly or what would happen if the check did not come.*

Large employers were an exception, expressing preference for paying members directly. For large businesses that are computerized, paying employers creates an "exception processing" problem that requires significant administrative time and energy to deal with.

From the state's perspective, paying employers is administratively simpler. However, the DMP gives them greater control over how the state spends its money and who gets enrolled in which programs. Paying members also moves the locus of control over participating away from employers, potentially removing a barrier to enrollment.

Some employers suggested a positive aspect of paying members directly would be that their personal situations would remain confidential to the employee. Employees did not concur, being more concerned with how the subsidy would come to them and if they would have less money or have to wait for the check.[6] Generally insurers suggested direct member payment might bring them more business because employers cannot act as gatekeepers, but they considered the potential number of lives to be negligible. They expressed mild concerns about adverse selection, but basically did not think the numbers would impact them.

The most consistent concern raised about the employer payment was that it creates a perverse incentive – employers are expected to volunteer for a program that costs them money in employee health benefits. By agreeing to participate they knowingly take on a financial burden that they feel the state is now fully carrying. Most respondents acknowledged that this creates a barrier to successful roll-out of the program and, as in other states that have taken this approach, invariably constrains overall program success. One employer who does not participate put it directly,

[6] At the time of the study none of the enrollees were receiving direct member payments.

…it's going to mean that all those people are going to join our plan and cost us money that we don't have to put out now so I'm against it.

A minority of the brokers interviewed echoed this sentiment and said they do not market the program because it is an added cost to their clients with very little return on their investment. One broker suggested that commercial carriers could create incentives for small employers to participate in RIte Share through their pricing structures.

…this would give [brokers] more incentive to put it in…then I am value-added in offering it.

As a balance to this concern, however, most employers interviewed expressed support for the program and for their responsibility as employers to provide benefits to their workers. Employers interviewed, including those that are not eligible or do not participate for other reasons, listed reasons for supporting the program including attracting and keeping good workers, their social responsibility, the potential to open up broader health plan choices with a larger group, and the fact that low income workers are mainstreamed in the health care system (i.e. treated better by providers, etc.).

State administrators and advocates raised concerns that employers would game the system and find structural ways to avoid participating including offering only health plans that do not qualify, ending employee health benefits and offering cash payments instead, and raising premium shares to make the plan fail the cost-effectiveness test. While voluntary participation has not been robust, employers did not indicate that they were actively pursuing obstructionist tactics or taking away health benefits. This will be important to monitor, however, given the downturn in the economy and increases in unemployment.

The present tempest brewing over the issue of who gets paid the premium subsidy, stems from the mid-implementation addition of the DMP. While the state's position is that it was intending all along to implement both approaches, the business, insurance, and broker communities view it as a change in the state's attitude toward employers. As noted above, employers originally supported the direct member payment as a more transparent approach for them. As they became more sophisticated about the program they realized that by receiving the checks directly, they had control over the decision to participate. The addition of the direct member payment is viewed as creating a back-door mandate that will not just shift the locus of control, but will put them in the untenable position of being "blindsided" with unplanned expenses.

Insurance brokers highlighted the problem emerging from the way the policy was changed:

It is not that it isn't the right thing to do or that most employers won't participate in the program if you approach them right…that it's the right thing to do from a social responsibility thing. The problem is that employers do not have enough information to act rationally.

Particularly with small businesses the issue is not mostly how much it costs, but the ability to project costs and plan. Most employers can accommodate the added costs if they can rationally project them – but you just can't expect particularly small, low margin businesses to suddenly take on that cost. The employer doesn't have a way to know how many people they are going to have to absorb.

And,

The program started out voluntary. We spent a lot of time with clients trying to determine contribution strategies and plan designs for 2002 and now they get hit with RIte Share as mandatory…switching in mid-stream is a problem.

Several respondents, notably advocates, commented that the structure of the program as a mandate unfairly targets small businesses and those that employ low wage workers.

Unless we mandate every employer has to cover every employee, we shouldn't mandate that one strata of employers are forced into it and not others…it's mostly low margin employers who are getting this mandate.

Further, the relationship of this to reform in the small group market was emphasized. As long as the small group insurance market continues to experience rapid rate increases and high administrative costs, respondents noted, the same employers that are being targeted by RIte Share are the ones that will be most pressed in the commercial sector.

Employers, who for the most part support the idea and intent of the program, expressed concern that the state will eventually pull back the amount of the subsidy or end the program altogether and that they will be "stuck" with the full cost of their employees. According to employers interviewed this will affect their behavior regarding the type of health benefits offered to employees and amount of cost participation expected of all employees.

Paying the Premium - What Works Best?

According to the respondents' comments, the program's approach to providing the premium subsidy has mixed reviews. Some of the ambiguity stems from the mid-implementation of the DMP. Each approach has its benefits and negatives for overall program health.

1. Administrative ease or burden – paying employers is overwhelmingly considered to be simpler and cleaner for all stakeholders for whom it is an issue, excepting large employers for whom it creates processing problems. Alternatively, direct member payment is seen as having the potential of

creating significant administrative hardships for employers, enrollees and the state and is viewed warily by most stakeholders.

2. Encouraging enrollment and program growth – maximizing program performance on this goal is far less clear from the perspective of who gets paid. On the face of it there is no doubt that DMP has greater enrollment potential because it sidesteps the employer's gate-keeping prerogative. Paying members directly allows the state and enrollees greater control over program participation. Combining direct member payment with mandatory participation for enrollees potentially can maximize participation. Relying on employer voluntary participation alone probably will not result in robust program growth. However, negative responses from employers to direct member payment may counterbalance the benefits.

3. Encouraging overall program success – the potential fall-out from turning to direct member payments may well be a change in employer health benefit offering behavior and political pressure that attenuates the gains made by moving gate-keeping control to the state. Respondents expressed concern about the lobbying efforts against the program that may result from the squeeze employers are feeling. There is also potential that the attention drawn to RIte Share will spill over to RIte Care and jeopardize that program. In terms of overall program success, then, changes in the payment mechanism could cause more harm than good unless a positive incentive/reward for employers is developed.

RIte Share Design: Broad Qualifying of Commercial Plans with Expanded Benefit and Co-Payment Wrap-Around

In developing their approach to benefit requirements and plan qualifying, Rhode Island chose to piggy-back on the most popular commercial plans and provide a wrap-around of additional benefits and co-payment coverage offered in RIte Care. This approach causes the least disruption of the commercial market and minimizes negative impact on insurers. Also, given the limited number of commercial carriers and plans in Rhode Island, this means that almost every group plan on the market will qualify[7]. Alternatives to this approach would be to develop a uniform plan (i.e. a "RIte Share" plan) that is marketed separately to employers, to allow employers to buy-in to RIte Care for eligible employees, or to provide subsidies for purchasing the employer sponsored plan without any wrap-around. States that have chosen to develop unique products, most commonly basic benefit packages, have run into significant problems. First of all, agreeing to what should be included in a basic package is a political nightmare. Even in states where this approach has been taken, disagreements and challenges are ongoing. Second, creating a new product further complicates the market rather than simplifying it,

[7] The one exception to this is that plans with deductibles cannot qualify due to computer processing and data inputting constraints with the state claims processing contractor. This problem is being dealt with and it is anticipated that plans with deductibles will be able to be included.

runs the risk of alienating commercial insurers, and creates a product that almost no one is satisfied with.

The RIte Share benefit design places enrollees into the employers' plans giving them access to the panel of providers and benefits of that plan without losing the broader coverage that RIte Care affords. The intention of this approach is consistent with the state's philosophy of minimizing disruption in the commercial market and provides for administrative simplicity for the employer and insurer. Providing the broad benefit wrap-around meets the state's goal of continuing to enhance health care access and health outcomes for medically underserved and low income people. The wrap-around benefits and co-pay coverage, as described above, are handled through an additional medical assistance insurance card.

In general, employers did not have strong opinions about the benefit package. Most supported the comprehensive package as a recruiting benefit. They did not feel that having employees with different benefits would cause problems in the shop.

Among those opposed to the wrap-around feature, there were opposing recommendations for changing the program. One recommendation was that the program should either subsidize whatever plan employers offer (most common response from employers, insurers, brokers, state administrators, providers); the other was that employers should be able to buy into the RIte Care program (advocates).

Concerns about the wrap-around benefits fell into several categories. The first issue raised by respondents across the groups was philosophical, questioning the richness of the package in itself and also whether the choice to cover fewer with more was the best way to invest state dollars. That is, is it "right" to offer such a broad set of benefits when it means that the extra cost will necessarily limit the number of people the program can accommodate? Wouldn't it be "fairer" to assure that more people have access to something basic? As one broker put it,

> *…The reasons for doing it are good but isn't it ironic that people who qualify for medical assistance get better coverage than those who pay out of pocket?*

Of course, as a nation this issue forms the basis of our debate about the right to health care, one that we have yet to resolve. On the one hand, there is no doubt from a health outcomes perspective that people should have access to comprehensive health services. On the other hand, as long as resources to pay for health care are constrained, the question of rationing will remain not whether to do it but how to do it.

All respondents, even those who support comprehensive services, raised the issues of administrative burden and confusion. Specifically, confusion resulting from the dual insurance systems and the need for two cards and on administrative burdens. Again, it is important to remember that at the time of this study most providers had not seen many, if any, RIte Share patients. Providers, enrollees and advocates all voiced concern over how well the two card system will work. Providers commented that it is incumbent upon the patient to mention that they are RIte Share members and to show the two cards for their wrap-around to be acknowledged. If only the commercial card is presented the provider's staff will assume the patient only has that coverage.

If RIte Share membership is not raised by the patient the provider is unlikely to know and will end up billing either the commercial carrier or the state inappropriately. In the instances where this has occurred providers have received rejections from both and have had to undergo lengthy administrative procedures to correct the billing and obtain reimbursements. Some providers stated that patients are continuing to give them only their RIte Care card and that when they submit the bill to the state it gets rejected. Both providers and enrollees expressed confusion over how the two card system works.

A second administrative problem for providers is that, unlike most coordination of benefit procedures where providers bill carriers consecutively, the RIte Share program requires concurrent split billing. Although one state administrator had commented that RIte Share would be no different than other gap policies, provider systems are generally not set up for concurrent split billing. While all providers interviewed emphasized this problem, the pharmacy respondents had particular difficulty from an administrative perspective. One pharmacist stated flatly that *"…we just can't do split billing and we are requiring co-payments from enrollees."* It was felt that the enrollee would have to pursue the reimbursement after the fact.[8] Concern was raised over whether low income workers would put off getting needed prescriptions because they did not have the money or could not negotiate the process for getting the reimbursement from the state. This same respondent commented that there has been confusion over medical assistance numbers between the two programs. One employer noted that they had to call a pharmacy to clarify that the Rite Share enrolled employee did not have to pay co-pays.

State people and insurers overwhelmingly support not having the wrap around benefits for administrative reasons. For insurers the problems stem mostly from errors in claims submissions by providers and the general confusion that providers and enrollees are experiencing. State administrators expressed concerns about the administrative complexity and the cost to the program of having to manage both qualifying plans and doing claims processing for services and co-pays. The co-pays were specifically highlighted as problems as they come from both providers and enrollees. As one insurer said, "*The state is not in the insurance business*".

For those whom comprehensive benefits are emphasized, concerns were raised about how quality and continuity would be affected by having separate systems of care. Focal for these respondents were the potential impact on health outcomes of the enrollees and the integrity of the RIte Care program.

Advocates, providers, and state respondents were very clear on the appropriateness of providing broad coverage, noting that previous to RIte Share most of

[8] These comments were not made in a hostile way but did indicate that it would be "business as usual" regardless of the RIte Share program design.

the enrollees were in RIte Care and had access to comprehensive care. As a Medicaid program, RIte Care offers a comprehensive benefit package because it has been shown that low income and medically disenfranchised populations experience barriers to care that the rest of the population does not. Cultural, language, transportation, and other enabling services form the very basis upon which people are able to utilize the health care system, and without these services they would not get care. The tradition established by RIte Care of attaining high marks for improved health outcomes is a testament to continuing to emphasize comprehensive health care. However, while supporting the wrap-around, advocates also voiced strong concerns over the fragmenting the delivery system and the complexity of the program. Their remarks focused on knowing if people actually were getting care, how good the care was, and whether enrollees would be able to navigate the system. In other words, whether the integrity established in RIte Care would be continued under RIte Share.

At the heart of respondent's support is a commitment to the RIte Care program as a model Medicaid program and health care delivery system. As noted above, RIte Care is held up nationally as a quality program for its positive health outcomes and broad eligibility thresholds. In the words of one advocate

> *…we had a really elegant system…its all fragmented now for service provision and data collection…with RIte Care we were able to deliver services fairly seamlessly but now we don't know what's going on…we don't have any data.*

Advocates question whether enrollees understand the program and whether they are actually able to access services. This concern particularly pertains to the wrap around benefits. There were several specific concerns raised about enrollees negotiating the system. Under RIte Care people were in a coordinated system of care through which they accessed all services. Their primary care provider, specialists, and ancillary care providers were all linked together. Particularly for those utilizing community health centers, there was a comprehensive, care-coordinated approach with referrals and follow-up emanating from the primary care provider. The effectiveness of this system was monitored for both efficiency and health outcomes. Under RIte Share, patients have to negotiate the system themselves, many have had to select new providers[9]. Disruption in continuity of care has a negative impact on health outcomes and causes duplication of effort and increased costs. Because the commercial plan benefits and wrap-around services are part of different systems of care there is concern that there will be a lack of coordination and potentially a lot of confusion. The preference of respondents from the advocate community for a RIte Care buy-in program for employers reflects emphasis on maintaining a unified and monitored approach.

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[9] Of the three health insurers in Rhode Island, Neighborhood Health Plan of RI does not offer a commercial product. Enrollees who had coverage through NHPRI under RIte Care will have to change plans when they move into RIte Share. This may not have an impact on everyone in terms of choice of primary care providers as many plans have common panels, however it may impact a significant number of people who use community health centers for their primary care.

Enrollees expressed support for the program and stated that they like the feeling of having "regular insurance". One enrollee commented that s/he felt providers treated them differently when they showed their RIte Care card and hoped they would be handled better with the commercial card. They also supported having more comprehensive benefits, particularly those that reduce barriers to accessing care such as language translation and transportation. These respondents echoed many of the concerns raised above, however, particularly confusion over the way the two cards work, how they access services that are "out-of-plan", what to do when providers ask for co-pays, and how to get reimbursements when they do pay out of pocket. None of the respondents who are members had utilized wrap-around services at the time of the interview. One enrollee expressed concern that the program would end and they would be left without any insurance.

Wrap-Around Benefits…How Are They Working?

As with the previous design feature, the wrap-around benefits elicited mixed reviews. There was more consistency among stakeholders about administrative problems, but also reasonably strong support for comprehensive benefits from a quality of care perspective.

1. Administrative ease or burden – administratively, wrap-around benefits seem to cause significant administrative problems for providers, the state, insurers, and enrollees. While advocates and enrollees are supportive of comprehensive benefit packages (as are state administrators on a philosophical level), the fragmented structure of the program creates problems. The approach has little impact on employers administratively other than when they have to clarify employee and provider confusion.

2. Encouraging enrollment and program growth – employers indicate that the wrap-around benefits may serve as a labor recruitment tool and could potentially encourage them to participate during a period of tight labor market. Otherwise, this design feature does not contribute to or detract from program enrollment growth. This is particularly true since enrollees do not have a choice whether to participate or not. The question of how resources are distributed and the cost of the wrap-around could impact the program's budget and limit the number of people who are enrolled.

3. Encouraging overall program success – the wrap-around benefit approach elicits strong reactions from most stakeholders – albeit very different sentiments. Concerns focus on quality of care and access to services, administrative difficulties, and cost to the program. Advocates and enrollees, generally support broad benefits, a support tempered by their concerns about how well the program will work, however, the administrative problems for other stakeholders may build substantial roadblocks to participation in the program. In addition, the cost to the state of administering the program is

increased significantly by the complex claims processing required by the wrap-around. Given the downturn in the state economy and the pressure on state agencies to reduce budgets, alternatives such as a RIte Care buy-in or purchasing employer plans may need to be explored.

RIte Share Design: Employer-Based Cost-Effectiveness Test

Rhode Island has taken an innovative approach to determining the cost-effectiveness of moving an enrollee from RIte Care to RIte Share. The cost-effectiveness rule requires that a person who is eligible for medical assistance be placed in the program (RIte Care or RIte Share) based on which program has lower costs for the state. The formula involves assessing the cost of the employer plan and the size of the family. Prior to Rhode Island, states administered the cost-effectiveness test individually for each eligible and their family. This is a very time consuming and cumbersome approach. Rhode Island pioneered the employer group level cost-effectiveness approach, whereby the average cost for the employer's group (broken into three tiers) is taken as the threshold. This approach is significantly more efficient administratively for the state and requires that the employer only be engaged in one determination process. The federal government is now recommending this approach to other states.

In terms of this study, this design feature is the most technical – and the one most transparent to the majority of stakeholders. For that reason there was little comment from respondents other than the state and insurers.

Of the respondents that had comments, most were supportive of this approach with a few caveats. The one large employer who was familiar with the cost-effectiveness test approach was supportive and stated that it was administratively easier for them. The employer-level approach made requalifying easier when they change co-payments or other plan features. This employer also commented that it is easier as a labor recruiting tool to be able to just say that they offer that benefit as opposed to going through a confusing discussion about family size and individual circumstances.

Concern was expressed by some respondents that people could fall through the cracks, i.e. that some employer group may not qualify overall, but that there may be individuals that would have. From an enrollee perspective, the person would stay in RIte Care and therefore still have coverage. This would, however, represent lost opportunity for the state to move people into RIte Share and capture some employer contribution.

Respondents from the advocate community, the state, and insurers keyed in on the relationship between the cost-effectiveness qualifying test and small group market behavior. Although this does not address the employer versus individual approach question, it is critical for the success of the program. There is near universal agreement that the cost-effectiveness test may be the weakest link in the program – and the one over which the Department of Human Services has no control. The cost effectiveness test creates thresholds in the cost of the subsidy above which it is a better financial arrangement for the state to keep enrollees in RIte Care (and a condition for federal matching funds). Increases in the employee's costs can come about either through targeted cost-shift to employees by employers, because of overall increases in the cost of health benefits, or both. The lack of regulation in the small group market and the concomitant rapid increases occurring particularly for small employers are headed toward pricing many more people above the cost-effectiveness threshold. Although the cost-effectiveness test can be gamed by employers intent on not qualifying, what seems more likely is that many will not pass due to broader market effects.

Employer-Level Cost-Effectiveness Test – Is it Better?

Again, there was very little familiarity with this design feature except among state and insurance respondents. Many respondents instead discussed the ramifications of small group market reforms on program success.

1. Administrative ease or burden – approaching the cost-effectiveness test at the employer group level is clearly the simplest from an administrative perspective for the state and employers.

2. Encouraging enrollment and program growth – doing the cost-effectiveness test at the employer level tends to be more inclusive and biases costs initially in favor of the employer thereby encouraging participation.

3. Encouraging overall program success – small group reform, or lack thereof, will potentially impact the cost-effectiveness threshold and disqualify many employers. Although employers can purposely orchestrate that plans do not qualify by cost-shifting to employees, rising premium costs and instability in the small group insurance market pose a greater threat to the potential success of the program.

RIte Share Design: Mandatory Enrollment in RIte Share For Medicaid/SCHIP Eligibility

The fourth design feature of the RIte Share program examined in this study is mandatory enrollment in RIte Share as a condition of eligibility for Medicaid and SCHIP. At the beginning of the program both employer and enrollee participation were voluntary. Enrollees were identified by combing the RIte Care rolls for people employed and going to the identified employers in the hope of gaining their participation. Phasing in mandatory enrollment was planned from the onset for several months into implementation. The impact of this change was to allow the state to capture not only people already enrolled in RIte Care, but also new people coming in. During the voluntary enrollment phase, it was also necessary to market to RIte Care enrollees. Under mandatory enrollment, the eligibility process is a triage point for the state to determine appropriate placement. With the implementation of Direct Member Payment and mandatory enrollment, the state maximizes its control over who goes into what program and when.

From the state's perspective, the move to mandatory enrollment was necessary to ensure program growth. Coupled with direct member payment it probably is the optimum approach to increase enrollment. However, reliance on the welfare intake system was seen as problematic and respondents in all groups of stakeholders expressed concern about how efficiently and effectively field workers would adapt to the change in procedures; over whether people would end up hanging in limbo, i.e. becoming uninsured, because the employer plan documentation and other process issues are not dealt with in a timely fashion. The following encompass the comments of many respondents:

> *…because enrollment depends on field offices for doing eligibility a lot of people will fall though the cracks or be left waiting and uninsured. There is a serious lack of communication between field offices and central – particularly RIte Share type programs that they don't see as the core of their job*

And,

> *…when you make it mandatory you force people into a place that no one can guarantee is working…*

Providers generally supported the enrollment mandate, however the focus was not on increasing enrollment per se, but rather on the ability to move people into commercial products. As commented on by both physicians and state administrators, physicians consider reimbursements under RIte Care to be inadequate so moving people into commercial plans improves their reimbursement rates. Providers also felt that employers should have to provide support for the health care system through paying something toward employee's health insurance. Insurers also were supportive of the approach because they felt it would increase the number of commercially covered lives, but were concerned that employers will respond by cutting back benefits.

Reactions to mandatory enrollment among employers were mixed. Among employers who participate, the focus was more on the process of getting employees enrolled. These employers generally did not like having any added work, but were not overly concerned about the added administrative burden of filling out benefit plan worksheets for employees. These employers were concerned that they might have to complete many individual forms and preferred a single qualifying approach. One supportive employer commented that if it did get too annoying they would just add deductibles or increase co-pays so that they would not qualify. Employers who are not participating were uniformly against mandatory enrollment.

However, many of the employers' reactions were based more on their perceptions that the state made a mid-stream change that contradicts what they were originally told, and that puts them in a more difficult position. As noted above regarding direct member payment, employers and brokers focused on the need for businesses to be able to project costs and rationally plan for employee benefits, and were uniformly against any kind of mandated participation.

Mandatory Enrollment for Medicaid/SCHIP Eligibility – How Will It Help?

Mandatory enrollment is a basic requirement for program enrollment growth. Coupled with DMP it provides the state with the ability to control entry into the program. With both design features implemented, from a technical point of view, participation by employees and employers becomes non-voluntary. The two critical events that can limit program growth at this point are 1) if employers choose to redesign or do away with employee benefit plans so that they do not qualify or do not meet the cost-effectiveness threshold, 2) if the rates in the small group market rise to the point where few plans meet the cost-effectiveness threshold.

1. Administrative ease or burden – mandatory enrollment adds administrative effort for both the state and employers. On the state side, any new procedure causes ripples in the system and needs time and patience to work through. Barring any major problem this should be workable and should not detract from the program. It is critical that attention is paid to how difficult and lengthy it is for enrollees to move through eligibility screening with the added procedure. Steps can be taken rather easily to ensure that effort required of employers is minimized.

2. Encouraging enrollment and program growth – mandatory enrollment is probably the most effective tool for maximizing RIte Share growth. Coupled with direct member payment the state has near total control over how many people are moved into the program from RIte Care, along with new enrollees who become eligible for medical assistance. The one large caveat is the state has no control over employers finding ways to become not qualified and/or dropping employee coverage altogether or over behavior of the small group market.

3. Encouraging overall program success – mandatory enrollment has all the potential to grow the RIte Share program, to provide savings for the state in direct service costs, and to add employer contributions to the revenue stream. All of these contribute to the potential success of the program. On the negative side, employers may be encouraged to find ways to not participate and/or may organize politically against the program. Resolving the processing issues so that people do not become stranded in a holding pen without coverage is critical as well.

SUMMARY

Rhode Island has been a leader nationally in the breadth and quality of their RIte Care program. Through expanding eligibility and aggressively outreaching to enroll people, Rhode Island has attained the lowest rate of people without health insurance of any state in the country. Statistics show that people in RIte Care have improved health outcomes and experience a high level of health care. As noted in the discussion, advocates have praised RIte Care for being "an elegant…and fairly seamless system" of care.

It was their very success that created the tension that led Rhode Island to explore implementing a premium assistance program. Rapidly increasing RIte Care enrollment coupled with instability in the commercial insurance market caused concern over the state's growing expenditures on health care for medically underserved and low income people. In order to preserve the great strides the state had already taken, the state entered into a public dialogue on the best way address the growing tension. Several models were considered including a purchasing pool that was fought strongly by the insurance industry. A RIte Care buy-in model for small businesses that was rejected because it was seen as another expansion of the program and because it was projected that there would be an influx of higher risk lives into the pool. It was decided to move forward with an employer-sponsored insurance premium assistance program.

Several reasons for choosing the particular design features of RIte Share are evidenced in the conversations with state respondents. Priorities in designing the program were 1) to create as little disruption in the commercial health insurance market as possible, 2) to take full advantage of federal matching funds, 3) to utilize the existing Medicaid infrastructure and avoid bureaucratic duplication, 4) to capture additional revenues and save state dollars through employer contributions. It is clear in the design of the program that the overarching goal was directed at preserving the integrity of RIte Care. This has been accomplished as RIte Care enrollment has been stable during 2001.

Unlike other states such as Massachusetts, Rhode Island has not directed efforts toward reducing the uninsured either by adding a buy-in vehicle for self-employed, or implementing mechanisms to encourage employers who do not offer health insurance benefits to do so. This may be the next step after RIte Share is fully implemented. Of course, given that Rhode Island has the lowest rate of uninsurance in the country, the focus on controlling costs in RIte Care and maximizing employer contributions for those on medical assistance are understandable. This latter emphasis is one of the successes of the Rhode Island program. Through implementing RIte Share, Rhode Island has been able to combine several revenue streams and has augmented the financing coming into the health care sector through additional matching funds and by leveraging state dollars with employer contributions. It will be important, however, for the state to watch the impact of the downturn in the economy on unemployment and health insurance coverage. If the economy continues in recession an additional effort aimed at expanding access to insurance coverage to those outside of the franchise may become important.

It is important to note that experiences in Iowa and other states that have implemented premium assistance programs show that many of the problems being evidenced in Rhode Island with RIte Share become benign as the programs mature and employers and enrollees become accustomed to them. As with anything new and different, but particularly with programs a complex as RIte Share, implementation is never easy. The results of this RIte Share Phase I Implementation Study reflect these experiences from other states. Premium assistance programs can be understood as efforts to increase contributions from employers while decreasing direct service expenditures for the state by moving people out of full public cost to partial public cost by piggy-backing on the employer based health insurance system. On paper this is a logical and fair approach. Accomplishing it is a far more difficult endeavor. Ideally, the program will be successful because the state is able to offer an approach that employers will participate in because the feel they are getting a fair deal for their investment, the return in terms of labor recruiting and social investment outweigh costs, and they can accommodate the added expense in their business. Creating this ideal, however, involves developing complex infrastructures that are reasonably simple for everyone to manage; negotiating every aspect of the program with a myriad of very invested stakeholders while maintaining program integrity; saving money while investing significant resources on design, implementation, and marketing.

Overall program growth has been slow but steady. The state's initial enrollment strategy of combing the RIte Care rolls to find people who could be moved to their employer sponsored insurance is logical given the goal of reducing the threat to Rite Care. Once identified, people with access to ESI could be moved to RIte Share, having the immediate positive effect of reducing enrollment figures. Given the less than robust participation rate of employers, it makes sense that the state would add direct member payment to employer payments. Expanding outreach to the point of eligibility screening and recertification and adding the enrollment mandate addresses the other side of stabilizing RIte Care, limiting explosive program growth. Implementing both employee and employer directed payments have been found necessary in other states that are experimenting with premium assistance programs. Relying on employer payments alone has not produced adequate enrollment response to sustain programs.

In spite of some claims by insurers to the contrary, it does not appear that RIte Share is encouraging employers to drop coverage or that employees are leaving employer sponsored coverage to go on medical assistance. This may have been happening previous to implementing RIte Share when outreach workers were going into small employers and recruiting eligible people for RIte Care enrollment. The structure of RIte Share, targeting people already on and/or eligible for medical assistance who are working where ESI is available, creates an adequate constraint to this.

Summary of Findings: Lessons Learned

Overall Comments

- *Employers generally are supportive of participating in the program and providing health insurance coverage but have concerns about whether the state will continue to support the program and whether the state will keep making changes they view as not in their interest.*

- *The RIte Care program is viewed as providing high quality care and positive health outcomes. There is concern that people will experience less continuity of care and access under RIte Share.*

- *Continued instability and lack of regulation in the small group commercial insurance market will lead to failure of the program as employers are priced out of health insurance or cost-shift more to employees.*

- *Rite Share presents the opportunity to broaden the revenue streams supporting the state's health care expenses and to leverage state dollars with employer contributions.*

Employer Payments and Direct Member Payments

- *Mandatory enrollment coupled with direct member payment gives the state greatest control over enrollment choices and maximizes program growth, but creates problems for employers and employees:*

> "The sudden implementation of both DMP and mandatory enrollment combined with the rolling nature of eligibility screening and recertification mean that employers cannot project costs and make rational business plans."
>
> "Enrollees are low wage workers, often transitory, and may not have adequate income to cover payroll deductions or to carry them until the state check arrives. Care has to be taken to assure that both employers and enrollees are financially protected."

- *The loss of control over whether to participate due to implementing direct member payments is not emphasized by employers and generally will not encourage them to drop insurance or try to get out of qualifying.*

Plan Qualifying and Wrap-Around Benefits

- *There is near universal agreement that the wrap-around benefits and co-payment coverage create administrative complexities and confusion.*

- *The bifurcated approach to coverage fragments the health care delivery system and the need for two insurance cards is confusing for providers and enrollees.*

- *Not creating a special RIte Share insurance plan was the right choice; subsidizing existing employer sponsored plans would be administratively easier.*

- *Access to comprehensive care and reducing the chance that out of pocket costs will deter seeking care are important – but the structure of the program may not assure access.*

Employer-Based Cost-Effectiveness Test

- *Universally seen as the most efficient approach – the only concern being that all eligible people get identified.*

Mandatory Enrollment

- *Understood as the best way for the state to maximize enrollment and control triage into the state's programs.*

- *Employers need to be able to project the number of people in their health plans and know when people will be coming into the benefit program. Rolling eligibility and recertification make it hard for them to plan their benefit packages and project costs.*

- *There is concern that lack of efficiency and effectiveness in adopting the added procedures by welfare field offices will leave people stranded without coverage while they try to gather required information.*

RECOMMENDATIONS

Increase information and education. On the marketing side employers felt increased direct outreach would increase employer participation. While some had heard of the program from their brokers, most had come across information informally. On the information side, it was clear that people are confused as to the fundamental structures of the program. They are not clear on who is eligible, how they get enrolled, what the risks are to employer and employee, etc. At the same time, sending out mailings is not effective. Many respondents commented that they get so much "stuff" from the state and they do not read it. An increase in clearly written materials and direct contact would alleviate these problems.

Implement a data tracking system. This would provide critical information to the state on how well the program is working and could allay some of the concerns of advocates. The information system should monitor how well people are being transitioned into the program, how the wrap-around is working, both in terms of access and out-of-pocket co-payments, how well people and providers are managing the dual card system, whether people are actually getting care/services, and importantly, how the program is affecting health outcomes. The true costs savings and expenses of the state should also be analyzed.

Develop a mechanism for ongoing feedback from participants and stakeholders. The state should set a regular and ongoing schedule of focus groups/interactive meetings with stakeholder groups to get feedback and recommendations for improvements. This will allow state administrators to hear directly how the program works, but maybe more importantly will provide regular interface that can help alleviate built up tensions and problems. The present Business Advisory and Implementation Planning groups are not seen as adequate.

Establish a dedicated process for addressing the problems that rolling eligibility screening and recertification engender for employers. Work with brokers, insurers and employers to identify ways that the state can continue to maximize enrollment while also providing employers with the capability to project plan enrollment and costs.

Re-evaluate the wrap-around approach. Research and identify the experiences of providers and enrollees with the two-card system to see if people are actually receiving the care they are entitled to and whether providers can accommodate the concurrent split-billing problem. If the wrap-around is not effective, reconsideration should be given to how to provide comprehensive health coverage in a less administratively cumbersome and confusing way. If the wrap approach is working, directed education with enrollees and providers should be instituted.

Assess the impact of the program on continuity of care and the delivery system. By moving people into the commercial market, disruptions in existing relationships are bound to occur. These changes will impact patients and providers. For patients it represents a need to identify new providers. For both it causes breaches in ongoing care. The impact on safety net providers such as community mental health centers and community health centers should be analyzed to see how their payer mix and patient visits are affected.

Encourage state policy makers and legislators to increase oversight and reform of the small group market. Respondents from all stakeholder groups in this study emphasized, and it has been shown to be true in other states, that RIte Share could be the best program in the world and still fail if premium rates continue to spiral for small groups. The recent imposition of rate bands will most likely not be an adequate brake on premium increases.

The premium assistance approach has very little track record in other states. By taking this avenue, Rhode Island is serving as a testing ground for the rest of the nation. The lessons learned here can assist Rhode Island and other states in modeling the most attractive and successful programs. This study is an initial step in identifying what works and what does not, and can help point the way to reducing barriers to program growth and ultimate success.

APPENDIX A:

RITE SHARE PHASE I IMPLEMENTATION STUDY

INTERVIEW PROTOCOL

RITE SHARE DESIGN AND IMPLEMENTATION STUDY
INTERVIEW SCHEDULE

Date of Interview_____________
Code ______________________ Date Transcribed ____________

1. There have been a lot of things happening in the world of health insurance. What do you think are some of the biggest issues confronting us about health care and health insurance?

2. What do you think should be done to solve/address these concerns?

3. Do you feel that government has a role to play in making sure that people have health insurance (what kind of role? why? Why not?)

Now, lets talk about the RIte Share program. First of all, are you participating in the program? Why/why not?

Let's talk about some of the features of the program as initially introduced and how they are working for you. (probe for how well each works/doesn't work for respondent).

4. The RIte Share program pays the employee's premium share directly to employers - how has /does this work for you, and what, if any, difficulties result?:

5. The RIte Share program includes many of the insurance policies presently offered by insurers along with covering extra benefits and co-payments through a secondary, wrap-around policy. How does this approach work for you and what, if any, difficulties result?:

6. The RIte Share program qualifies people for participation based on the employer's whole group instead of family by family. How does this work for you (Probe specifically for impact on decision to participate, costs, administrative implications, etc. and overall program success)?

7. Under the RIte Share program, if a person applies for or is enrolled in RIte Care and they have access to a qualified employer plan, they must enroll in RIte Share to be eligible for Medicaid and/or State Children's Health Insurance Program. How does this work for you and what, if any, impact do you feel it has on enrollment, costs, etc.:

8. What are your thoughts on other design aspects such as co-payments or others?

9. Are there any specific problems, such as administrative burdens, that you experience with RIte Share? If so, how can the program be changed or modified to ease these problems?

10. From your perspective what works about RIte Share? What doesn't work? How can it be modified to work better for you?